

SECTION 3: PROGRAM DESIGN

INSTRUCTIONS and FORMS

ITEMS:

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25. Program Description
26. Staffing Pattern/Staffing Requirements
27. Accessibility
28. Admissions, Service/Treatment, and Discharge Procedures
29. Evaluation Plan
30. Client Characteristic Chart
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32. Anticipated Program Expenses (Forms 3 and 3S)
33. Anticipated Program Revenue (Forms 4 and 4S)

SECTION 3: PROGRAM DESIGN

COMPLETE SECTION 3 FOR EACH PROGRAM

24. Program Organizational Chart for *Disabilities Services*:

Provide an organizational chart which shows in detail, position titles and reporting relationships within the specific program being proposed. Include all positions for which funding is being requested.

25. Program Description for *Disabilities Services*:

Identify the name and number of the program for which you are requesting funding as it is identified in the *Year 2006 Purchase of Service Guidelines: Program Requirements*. The program description must include the following:

- a. Describe the needs to be met, the problems to be solved, and the target population(s) to be served by the proposed program.
- b. Describe what services will be provided to meet the identified need and how those services will be delivered.
- c. Describe the agency's capability to provide this program, including certification, licensure, and experience, and note any special staff qualifications (credentials, education, experience.)
- d. For programs which are provided at more than one site, provide the following information for each site:
 - (1) Address and telephone number of each site.
 - (2) Name and title of the person in charge of the program at the site.
 - (3) Hours of operation of each site.
 - (4) Differences in programs or services available at each site. If services provided at all sites are identical, include a statement to that effect.
- e. Describe service coordination efforts with other programs or agencies including purpose and frequency.

26. Staffing Pattern for Disabilities Services:

Describe the staffing pattern and its relationship to the volume of clients or services to be provided. For example, describe day service/treatment in terms of staff to client ratios, outpatient services in terms of client volume or case load per staff, and community prevention in terms of how many staff are needed to perform a particular activity. Community based residential facilities must submit a detailed description of how, by staff position, 24-hour coverage will be provided.

Agencies which provide services at more than one site must include a description of the staffing pattern for each site, if different. If the staffing pattern is the same for each site, include a statement to that effect.

27. Accessibility:

Provide a detailed description of each of the following items:

- a. Accessibility of the program to persons who are physically disabled including building accommodations such as ramps, doorways, elevators, toilet facilities, and if staff is available for persons needing assistance. Include copies of building plans or site surveys. If the program is not accessible, explain where the client would be referred or how disabled clients are accommodated.
- b. Accessibility for persons who are hearing impaired. List the name, position title, and level of training (registered or certified, level I or II) of staff who assist in sign language interpreting. Describe the knowledgeable use of TTY or Wisconsin Telephone Relay services. If no staff is available, explain where interpreter services would be obtained. Describe the training opportunities available to existing staff to develop sign language skills and recruitment procedures for hiring trained interpreters.
- c. Accessibility of the program for persons who are visually impaired including Braille signage present in the facility, or staff available for assistance in acquainting clients to the facility. Availability of materials in large print, Braille, and/or cassette recordings.
- d. Describe program accessibility for limited or non-English speaking persons. List the name, position title, and language (non-English) spoken. If no agency staff is available, explain how interpreter services would be obtained or where the client would be referred.
- e. Describe transportation availability to the facility including public, agency provided, or other arrangements.
- f. Describe outreach and case finding activities for special target populations such as minorities, women, or adolescents.
- g. Describe any differences in accessibility by program site.
- h. Availability of personal care assistance.
- i. Any other services which enhance program access.

28. Admission, Service/Treatment, and Discharge Procedures for *Disabilities Services*:

Address all requirements included in the Program Descriptions and Requirements section of these guidelines.

a. Admissions:

- (1) Describe the criteria used for determining client appropriateness for the program.
- (2) Describe the process for screening for appropriateness and admitting applicants to the program. The description of the process should begin with the initial contact and include all activities that occur prior to the establishment of the treatment/service plan. Provide detail about staff positions involved in the intake and assessment process and their roles and responsibilities in the process. Also include a description of the involvement of any specialists such as medical director, psychologist, etc.
- (3) Identify the major sources of referral into the program and the approximate percentage of referrals each source generates.

b. Service/Treatment Process:

- (1) Describe the program activities, purpose of the activity, and the usual size, structure, and schedule of activities or groups.
- (2) Describe the sequence of activities, the phases of service/treatment, the length of time in each phase, and the criteria used to determine movement from one phase to another.
- (3) Describe how and when individualized client treatment goals and objectives are developed, monitored, and reviewed. Identify by position categories who is involved in this process.

c. Discharges:

- (1) Describe the basis for discharge decisions and define a successful and unsuccessful discharge.
- (2) Describe the discharge process. Include any follow-up activities or monitoring of discharged clients.
- (3) Identify community resources to which clients are referred when discharged.

29. Evaluation Plan:

- a. Identify both program management and client related objectives (i.e., time tables, changes in behavior, numbers served, client satisfaction) which are specific to the program being described. Be sure to include the mandated outcomes specified in the program description on page 5 .
- b. Include a time frame and the expected level of achievement for each objective or outcome. Identify by site if appropriate.
- c. Describe how the agency will utilize program evaluation results.

The evaluation section of the application should outline who will conduct the evaluation, what data will be collected, what forms or assessment tools will be used. For agencies contracting with an independent evaluator, include the name and experience of the evaluator. For agencies conducting their own evaluation, identify the names of those responsible for the collection and compilation of the data.

All contract agencies are required to submit semi-annual evaluation reports based on their Evaluation Plan for respective programs. The reports are due 31 days after the end of the first six-month period. For example, evaluation reports for programs contracted in Calendar Year 2005 are due July 31, 2005 and January 31, 2006; evaluation reports for programs contracted in Calendar Year 2006 are due July 31, 2006 and January 31, 2007.

The semi-annual evaluation of the program should reflect the agency's success in achieving the program's goals.

The evaluation reports should be submitted to the following persons:

Disabilities Services: Virgil Cameron, Contract Services Coordinator
DHHS Contract Administration
1220 West Vliet Street, Suite 109
Milwaukee, WI 53205

30. Client Characteristics Chart:

Complete and submit the Client Characteristics Chart included in this section on page 85. Specify the number and percent of clients in **each** category within the age, sex, ethnic background, and other sections of the chart. Client Characteristics Chart Definitions can be found on page 84.

The total in each category must be equal to the number in Form 1, Column 1, Total Number of Clients to be Served per Year.

31. Program Volume Data:

Complete Forms 1 and 1A, for each program for which funding is requested. The forms and instructions can be found on pages 85 - 87. *Programs which are funded by site must include separate forms for each site.*

32. Program Expenses:

Complete Forms 3 and 3S, Anticipated Program Expenses and Supplementary Sheets for each program and each target population for which funding is being requested. Copies of the forms and instructions for completion are on pages 88 - 93. *Programs which are funded by site must include separate forms for each site.* Each Form 3 and 3S will appear as a separate column E on Form 5 and column D on Form 5S.

33. Program Revenues:

Report projected Year 2006 revenues for each program on Forms 4 and 4S. The forms and instructions are on pages 94 - 98. *Programs which are funded by site must include separate forms for each site.* Each Form 4 will appear as a separate column E on Form 5A.

CLIENT CHARACTERISTICS CHART DEFINITIONS

ETHNICITY DEFINITIONS

1. **Asian or Pacific Islander:** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes China, Japan, Korea, the Philippine Islands and Samoa.
2. **Black:** All persons having origins in any of the Black racial groups in Africa.
3. **Hispanic:** All persons of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. (Excludes Portugal, Spain and other European countries.)
4. **American Indian or Alaskan Native:** All persons having origins in any of the original peoples of North America, and those persons who maintain cultural identification through tribal affiliation or community recognition.
5. **White:** All persons who are not Asian or Pacific Islander, Black, Hispanic, or American Indian or Alaskan Native.

HANDICAPPED DEFINITIONS

A handicapped individual is defined pursuant to Section 504 of the Rehabilitation Act of 1973.

1. Any person who has a physical or mental impairment which substantially limits one or more major life activities (e.g., caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working);
2. Any person who has a record of such impairment; or,
3. Any person who is regarded as having such an impairment.

2006 CLIENT CHARACTERISTICS CHART

Agency Name _____
 Disability/Target Group _____
 Program Name _____ 2006 Prgm No.
 Facility Name & Address _____

CY 2006 Estimated

1. Unduplicated Count of Clients to be Served/Year (Form 1, Column 1):**2. Age Group:**

	Number	Percent (%)
a. 0 - 2		
b. 3 - 11		
c. 12 - 17		
d. 18 - 20		
e. 21 - 35		
f. 36 - 60		
g. 61 & over		
TOTAL		

3. Sex:

	Number	Percent (%)
a. Female		
b. Male		
TOTAL		

4. Ethnicity*:

	Number	Percent (%)
a. Asian or Pacific Islander		
b. Black		
c. Hispanic		
d. American Indian or Alaskan Native		
e. White		
TOTAL		

5. Other:

	Number	Percent (%)
a. Handicapped individuals*		
b. Not applicable		
TOTAL		

*The definitions for "Ethnicity: and Handicapped Individual" can be found in the
2006 Purchase of Service Guidelines - Technical Requirements.

FORM 1 - PROGRAM VOLUME DATA AND UNIT RATE CALCULATIONAGENCY NAME

Enter the legal name of the Agency

NAME AND ADDRESS OF PROGRAM SITE

Enter facility name and address. This is required only if the agency provides a service at more than one location. A Form 1 and 1A must be completed for each site (address) if the agency is reimbursed by site.

AGENCY FEDERAL TAX ID NUMBER

Specify the agency's tax status Federal Identification Number.

PROGRAM CATEGORY

Enter the **program category or Disability/Target group** exactly as they are identified in the *Year 2006 Purchase of Service Guidelines: Program Requirements*.

PROGRAM NAME

Enter the **program name and number** identifying programs exactly as they are identified in the *Year 2006 Purchase of Service Guidelines: Program Requirements*.

NUMBER OF PROGRAM OPERATING DAYS, HOURS AND CASES/CLIENTS

For direct service or client specific programs, this should represent the actual number of days per week and number of hours per day when services are being provided, and the number of cases (clients) per year that will be seen or provided services.

TYPE OF UNIT

Place an X in the box for an appropriate unit type (day, hour, 1/4 hour or other) on which Units of Service are calculated.

NOTE: Only one unit type can be indicated.

Column A: TOTAL PROGRAM UNITS

Specify the number of service units to be provided to each funding source listed in rows 1 to 5. Row 6 equals the total units entered in rows 1 to 5.

Column B: TOTAL PROGRAM COST

Include the projected total budget for this program category regardless of revenue sources. This total must be the same as the "Total Expenses Including Profit" line on Form 3 of the program.

Column C: PROGRAM COST BY FUNDING SOURCE

Indicate and allocate the total program cost to each of the funding sources listed in rows 1 to 5. Row 6 equals the total cost by funding source entered in rows 1 to 5, and should equal the total cost reported in column B.

Column D: COST PER UNIT

Indicate the cost per unit for providing services to each of the funding sources. Column D equals Column C divided by Column A.

FORM 1 - 2006 PROGRAM VOLUME DATA AND UNIT COST CALCULATION

AGENCY NAME _____

NAME & ADDRESS OF PROGRAM SITE _____

AGENCY FEDERAL TAX ID NUMBER _____

PROGRAM CATEGORY _____

PROGRAM NAME _____

(SELECT FROM TABLE OF CONTENTS)

2006 Prgm No. _____

NUMBER OF DAYS PROGRAM OPERATES PER WEEK _____

NUMBER HOURS PROGRAM OPERATES PER DAY _____

NUMBER OF CASES TO BE SERVED PER YEAR * _____

TYPE OF UNIT: ____ Month ____ Day ____ Hour ____ 1/4 Hour

Other: (Specify) _____

COST CALCULATIONS:

	TOTAL PROGRAM UNITS (A)	TOTAL PROGRAM COST (B)	PROGRAM COST BY FUNDING SOURCE (C)	COST PER UNIT (D)
1. DHHS Program	_____	_____	\$ _____	\$ _____
2. DHHS - LTS Program(s)	_____	_____	\$ _____	\$ _____
3. IPN / FFSN Programs or Services	_____	_____	\$ _____	\$ _____
4. MCDA (Aging) Program(s)	_____	_____	\$ _____	\$ _____
5. Other Programs	_____	_____	\$ _____	\$ _____
6. TOTALS	_____	\$ _____	\$ _____	\$ _____

* THIS SAME FIGURE IS TO BE USED AS THE "TOTAL" ON THE CLIENT CHARACTERISTICS CHART
A Form 1 must be completed for each site (address) if the agency is reimbursed by site.

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DATE SUBMITTED: _____

FORM 1A - UNIT OF SERVICE CALCULATION WORKSHEET

Use Form 1A to explain the methodology used to determine the Unit of Service level to be provided for each program included in the application.

AGENCY NAME:

NAME and NUMBER OF PROGRAM FROM THE YEAR 2006 *PURCHASE OF SERVICE GUIDELINES - PROGRAM REQUIREMENTS:*

NAME AND ADDRESS OF EACH SITE PROVIDING THE PROGRAM*:

PHONE NUMBER:

1. Explain how the Total Units of Service Per Year figure, shown in Form 1, Column A, was determined and show the actual calculations/method used to arrive at the figures for revenues received from Milwaukee County DHHS; DHHS Long Term Support; Department on Aging; and any Other sources of revenue.

2. Divide the Total Cost By Funding Source, Form 1, Column C, by the Total Units of Service Per Year, Form 1, Column A, to show the Unit Cost, Form 1, Column D.

Date Submitted:

*A Form 1 and 1A must be completed for each site (address) if the agency is reimbursed by site.

FORMS 3 and 3S INSTRUCTIONS

- 1 - 4 Name of Agency and **Program Name and Number**: Identifying information. Complete as explained for Form 1.

FORM 3 - ANTICIPATED PROGRAM EXPENSES

- Column A - A detailed chart of accounts for account definitions is available from DHHS Contract Administration (414-289-5778) upon request, or online at <http://www.county.milwaukee.gov/display/router.asp?docid=11327>.
- Column B - Fill in the 2005 Gross Budget by Control Account as adopted by the agency's Board of Directors or owners of the agency.
- Column C - Enter the total 2006 projected annual cost by Control Account as approved by the agency's Board of Directors or owners of the agency.

FROM FORM 4, BRING FORWARD THE TOTAL NON-DHHS CONTRACT REVENUE TO THE CORRESPONDING LINE ON FORM 3.

FORM 3 S - ANTICIPATED PROGRAM EXPENSES SUPPLEMENTAL SHEET

A supplemental Form 3S is to be used for each Control Account used on Form 3. A supplemental Form 3S is to be used to substantiate the amounts listed in Columns B and C. List only those Sub-Accounts actually used in the Control Account.

On Form 3S, specify by number of each Sub-Account with the corresponding Account Description in Column A; list the 2005 Gross Budgeted amount for each Sub-Account in Column B and the projected 2006 amount in Column C.

**SPECIAL INSTRUCTIONS FOR CONTROL ACCOUNT NUMBER 8000:
PROFESSIONAL FEES**

In addition to specifying on Form 3S, individual Sub-Account descriptions and budget amounts for each type of Professional Fee expense, include as an addendum to Form 3S, a copy of the actual memorandum of agreement between the agency and the person/agency providing a consultant-type service under the Professional Fee category. The memorandum of agreement should specify the name of the consultant, a description of the consultant functions, the projected number of consultation hours for the year and the hourly/monthly rate (whichever is appropriate.)

FORM 3 ANTICIPATED PROGRAM EXPENSES

Agency Name _____

Disability/Target Gp _____

Program Name _____

2006 Prgm No.

Facility Name _____

Address _____

	(A)	(B)	(C)
Control Acct. No.	Expenditure Description	2005 Gross Budget	2006 Gross Budget
7000	Salaries		
7100	Employee Health & Retirement Benefits		
7200	Payroll Taxes		
8000	Professional Fees		
8100	Supplies		
8200	Telephone		
8300	Postage and Shipping		
8400	Occupancy		
8500	Rental, Maintenance & Depreciation of Equipment		
8600	Printing and Publications		
8700	Travel		
8800	Conferences, Conventions, Meetings		
8900	Specific Assistance to Individuals		
9000	Membership Dues		
9100	Awards and Grants		
9200	Allocated Costs (From Indirect Cost Allocation Plan, if appropriate)		
9300	Client Transportation		
9400	Miscellaneous		
9500	Depreciation or Amortization		
9600	Allocations to Agencies, Payments to Affiliated Organizations		
	TOTAL EXPENSES		
	PROFIT FACTOR		
	TOTAL EXPENSES INCLUDING PROFIT		
	TOT NON-DHHS CONTRACT REV.		
	BROUGHT FWD		
	TOTAL DHHS REQUEST		

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FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

Agency Name _____
 Disability/Target Group _____
 Program _____
 Facility Name and Address _____

2006 Prgm No. _____

Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget	(C) 2006 Gross Budget
7000	7001	Executive Salaries		
	7002	Professional Salaries		
	7003	Clerical Staff Salaries		
	7004	Technical Salaries		
	7005	Maintenance Employee's Wages		
	7006	Temporary Clerical Help		
	7007	Student Stipends		
	7008	Other Staff Salaries (Unclassified)		

CONTROL ACCOUNT NO. 7000 SUB TOTAL*

7100	7101	Accident Insurance Premiums		
	7102	Life Insurance Premiums		
	7103	Medical & Hospital Plan Premiums		
	7104	Pension or Retirement Plan Premiums		
	7105	Supp. Payments to Pensioned Employees		
	7106	Payments to Annuitants		
	7107	Employment Termination Expenses		
	7108	Employee Tuition Reimburse. Plan		

CONTROL ACCOUNT NO. 7100 SUB TOTAL*

7200	7201	FICA Payments (Employer's Share)		
	7202	Unemployment Insurance		
	7203	Workmen's Compensation Insurance		
	7204	Disability Insurance Premiums		

CONTROL ACCOUNT NO. 7200 SUB TOTAL*

8000**	8001	Medical & Dental Fees		
	8002	Psychological Fees		
	8003	Legal Fees		
	8004	Rehabilitation & Education Fees		
	8005	Development & Public Relations Fees		
	8006	Brokerage, Commission, Collection Fee		
	8007	Employment Fees		
	8008	Audit Fees		
	8009	Electronic Data Processing Service Fee		
	8010	Other Contract Payments to Consultants		
	8011	Talent Fees		
	8012	Other Purchased Services		

CONTROL ACCOUNT NO. 8000 SUB TOTAL*

*Must be the same dollar amount as shown on Form 3

**Attach a copy of the memorandum of agreement between the agency and the professional when using Control Account No. 8000, Sub-Account Nos. 8001 through 8012.

FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

Agency Name			2006 Prgm No.	
		(A)	(B)	(C)
Control Acct. No.	Sub-Account Number	Account Description	2005 Gross Budget	2006 Gross Budget
8100	8101	Medicine & Drugs (Clinic Use Only)		
	8102	Prosthetic Appliances (Clinic Use Only)		
	8103	Recreational, Voc. & Craft Supplies		
	8104	Food & Beverages		
	8105	Laundry, Linen, & Housekeeping Supplies.		
	8106	Office Supplies-Stationery, Typing		
	8107	Paper, Ink, Printing, Duplicating		
	8108	New Goods Purchased		
	8109	Raw Materials (Manufacturing) Purchased.		
	8110	Manufacturing Supplies		

CONTROL ACCOUNT NO. 8100 SUB TOTAL*

8200	8201	Telephone Expense		
	8202	Telegraph Expense		

CONTROL ACCOUNT NO. 8200 SUB TOTAL*

8300	8301	Postage and Parcel Post		
	8302	Freight		
	8303	Messenger & Delivery Service		

CONTROL ACCOUNT NO. 8300 SUB TOTAL *

8400	8401	Office Rent		
	8402	Other Bldg. & Parking Lot Rent		
	8403	Bldg. & Bldg. Eq. Ins. (Gen. & Liability)		
	8404	Mortgage Interest		
	8405	Electricity		
	8406	Gas		
	8407	Heating Oil		
	8408	Water & Sewer		
	8409	Janitorial/Maintenance/Repairs Purchased		
	8410	Real Estate Taxes		
	8411	Personal Property Taxes		
	8412	Licenses & Permits-Occupancy Related		
	8413	Bldg. & Grounds Maintenance Supplies		
	8414	Miscellaneous Occupancy Costs		
	8415	Amortization/Leasehold Improvements		
	8416	Depreciation - Buildings		

CONTROL ACCOUNT NO. 8400 SUB TOTAL*

8500	8501	Equipment rental expenses		
	8502	Equipment Maintenance expenses		
	8503	Equipment - Depreciation		
	8504	Equipment - Interest Expense		

CONTROL ACCOUNT NO. 8500 SUB TOTAL *

FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

Agency Name			2006 Prgm No.	
		(A)	(B)	(C)
Control Acct. No.	Sub-Account Number	Account Description	2005 Gross Budget	2006 Gross Budget
8600	8601	Printing		
	8602	Artwork		
	8603	Photography		
	8604	Recording		
	8605	Films		
	8606	Subscriptions-Periodicals/Publication		
	8607	Purchase of Publications		
	8608	Media Use Charges-Public Information		

CONTROL ACCOUNT NO. 8600 SUB TOTAL*

8700	8701	Local Bus & Taxicab Fares		
	8702	Gas & Oil - Company Vehicles		
	8703	Repairs - Company Vehicles		
	8704	Insurance - Company Vehicles		
	8705	Licenses & Permits-Company Vehicles		
	8706	Leasing Costs - Company Vehicles		
	8707	Auto Allowance(Employees/Volunteers)		
	8708	Tires - Company Vehicles		
	8709	Hotel, Meals, & Incidental Expenses		
	8710	Depreciation - Automotive Equipment		

CONTROL ACCOUNT NO. 8700 SUB TOTAL*

8800	8801	Meeting Space & Equipment Rental		
	8802	Meeting Supplies (Notices,Badges,etc.)		
	8803	Food & Beverages Costs(Mtg. Particip.)		
	8804	Speaker's Honoraria & Expenses		
	8805	Registration Fees		

CONTROL ACCOUNT NO. 8800 SUB TOTAL*

8900	8901	Medical Fees		
	8902	Dental Fees		
	8903	Medicines		
	8904	Children's Board		
	8905	Homemaker Service		
	8906	Food Service		
	8907	Shelter Service		
	8908	Clothing Service		
	8910	Recreation Service		
	8911	Wage Supplements		
	8912	Prosthetic Appliances		
	8913	Hospital Fees		
	8914	Testing Fees		
	8915	Materials - Crafts, Vocation, etc.		

CONTROL ACCOUNT NO. 8900 SUB TOTAL*

FORM 3S ANTICIPATED PROGRAM EXPENSES SUPPLEMENTARY SHEET

Agency Name		2006 Prgm No.	
Control Acct. No.	Sub-Account Number	(A) Account Description	(B) 2005 Gross Budget
9000	9001	Individual Dues	(C) 2006 Gross Budget
	9002	Organizational Dues	

CONTROL ACCOUNT NO 9000 SUB TOTAL *

9100	9101	Grants to Research Institutions	
	9102	Graduate Fellowships	
	9103	Trainee Scholarships	
	9104	Other Scholarships/Tuition Payments	
	9105	Allowance for Travel Under Grant	
	9106	Allowance for Equipment Under Grant	
	9107	Lump Sum Camperships	
	9108	Contribution/Grants to Hum. Serv. Org	
	9109-50	Awards & Grants to Indiv./Other Org.	
9151-99	Awards & Grants to Affiliate Organizat.		

CONTROL ACCOUNT NO. 9100 SUB TOTAL *

9200	9201	Administrative Costs (Indirect Costs)	
	9202	Transportation	

CONTROL ACCOUNT NO. 9200 SUB TOTAL *

9300	9301	Local Bus & Taxicab Fares	
	9302	Gas & Oil - Company Vehicles	
	9303	Repairs - Company Vehicles	
	9304	Insurance - Company Vehicles	
	9305	Licenses & Permits-Company Vehicles	
	9306	Leasing Costs - Company Vehicles	
	9307	Tires - Company Vehicles	
	9308	Depreciation - Auto Equipment	

CONTROL ACCOUNT NO. 9300 SUB TOTAL *

9400	9401	Employee Malpractice Insurance	
	9402	Employee Bonding Insurance	
	9403	Other	

CONTROL ACCOUNT NO. 9400 SUB TOTAL *

9500	9501-9504	Depreciation or Amortization	
See Accounts Related to the Statement of Expenses in the GUIDELINES.			

9600	9601-9690	Allocations to Agencies,	
	9691	Payments to Affiliated Organizations	

CONTROL ACCOUNT NO. 9600 SUB TOTAL *

GRAND TOTAL ***

***Must be the same dollar amount as shown on Form 3, on the line titled "TOTAL EXPENSES"

FORMS 4 and 4S INSTRUCTIONS

1 - 4 Name of Agency and **Program Name and Number**: Identifying information. Complete as explained for Form 1.

FORM 4 - ANTICIPATED PROGRAM REVENUE

Column A - See detailed chart of accounts in the back of this section for account definitions.

Column B - Fill in the 2005 Gross Budgeted Revenues by Control Account. Total the Budgeted Revenue on the line provided. Total Revenue should equal Total Expenses including profit on Form 3.

Column C - Fill in the anticipated 2006 Revenues by Control Account as in Column A. The rest of the procedure for Column C is identical to that for Column B.

FORM 4 S - ANTICIPATED PROGRAM REVENUE SUPPLEMENTAL SHEET

For each Control Account used on Form 4, use a supplemental Form 4S, to substantiate the amounts in Columns B and C. List only those Sub-Accounts actually used in the compilation of the Control Account. On Form 4S, specify by number each Sub-Account with the corresponding Account Description in Column A, list the 2005 Gross Budgeted Revenue for each Sub-Account in Column B, and the projected revenue amount for 2006 in Column C.

FORM 4 ANTICIPATED PROGRAM REVENUE

Agency Name _____

Disability/Target Gp _____

Program _____ 2006 Prgm No.

Facility Name & _____

Address _____

	(A)	(B)	(C)
Control Acct. No.	Revenue	2005 Rev. Budget	2006 Rev. Budget
4000	Contributions and Donations		
4100	Contributions to Building Fund		
4200	Special Events		
4300	Legacies and Bequests		
4500	Collected through Local Member Units		
4600	Contributed by Associated Organizations		
4700	Allocated by Federated Fund Raising Organizations		
4800	Allocated by Unassociated and Non-Federated Fund Raising Organizations		
5100	Other Government Purchase of Service (DO NOT INCLUDE ANY REQUESTS FROM DHHS)		
5200	Grants from Other Governmental Agencies (DO NOT INCLUDE ANY REQUESTS FROM DHHS)		
5300	Revenues From HMO and PPO		
6000	Membership Dues		
6100	Assessments and Dues-Local Member Units		
6200	Program Service Fees - Other		
6300	Intra-Agency Sales of Supplies and Services		
6400	Revenues from Disposal of Assets		
6500	Investment Income		
6600	Gains (Losses) on Investment Transactions		
6900	Miscellaneous Revenue		
	TOTAL NON-DHHS REVENUE		
	DHHS CONTRACT REQUEST		
	TOTAL REVENUE		

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FORM 4S ANTICIPATED PROGRAM REVENUE SUPPLEMENTARY SHEET

Agency Name _____
 Disability/Target Group _____
 Program _____
 Facility Name and Address _____

2006 Prgm No. _____

		(A)	(B)	(C)
Control Acct. No.	Sub-Account Number	Account Description	2005 Revenue Budget	2006 Revenue Budget
4000	4001	In-Kind Materials		
	4002	In-Kind Services		
	4003	Unrestricted Cash		
	4004	Restricted Cash		
	4005	Other		

CONTROL ACCOUNT NO. 4000 SUB TOTAL*

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4100		Contributions to Building Fund		
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CONTROL ACCOUNT NO. 4100 SUB TOTAL*

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4200		Special Events		
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CONTROL ACCOUNT NO. 4200 SUB TOTAL*

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4300	4301	Endowments		
	4302	Trusts		
	4303	Other		

CONTROL ACCOUNT NO. 4300 SUB TOTAL*

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4500		Collected Through Local Member Units		
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CONTROL ACCOUNT NO. 4500 SUB TOTAL*

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4600		Contributed by Associated Organizations		
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CONTROL ACCOUNT NO. 4600 SUB TOTAL*

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4700		Allocated by Federated Fund Raising Org.		
	4701	United Way		
	4702	Other		

CONTROL ACCOUNT NO. 4700 SUB TOTAL *

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4800		Allocated by Unassociated and Non-Federated Fund Raising Org.		
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CONTROL ACCOUNT NO. 4800 SUB TOTAL*

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*Must be the same dollar amount as shown on Form 4.

FORM 4S ANTICIPATED PROGRAM REVENUE SUPPLEMENTARY SHEET

Agency Name _____

2006 Prgm No. _____

		(A)	(B)	(C)
Control Acct. No.	Sub-Account Number	Account Description	2005 Revenue Budget	2006 Revenue Budget
5100	5101	Title XX-Milwaukee County (Do not include any DHHS Requests)		
	5102	Title XX-Other Counties		
	5103	Title IVA (AFDC Unemployment Actual)- Milwaukee County		
	5104	Title IVA (AFDC Unemployment Actual)- Other Counties		
	5105	Title IVA (WEOP) - Milwaukee County		
	5106	Title IVA (WEOP) - Other Counties		
	5107	51.42/.437 - Milwaukee County		
	5108	51.42/.437 - Other Counties		
	5109	Title I - Milwaukee County		
	5110	Title I - Other Counties		
	5111	Title III - Milwaukee County		
	5112	Title III - Other Counties		
	5113	USDA Food Stamps		
	5114	Title XVIII - Medicare		
	5115	Title XIX - Medicaid		
	5116	Social Security and SSI		
	5117	CIP Revenue from Milwaukee County		
	5118	CIP Revenue from Other Counties		
	5119	COP Revenue from Milwaukee County		
	5120	COP Revenue from Other Counties		
	5121	Target Cities Voucher Revenue		
	5122	Other		

CONTROL ACCOUNT NO. 5100 SUB TOTAL *

5200	5201	Direct Federal Grants		
	5202	Direct State Grants		
	5203	Direct County Grants		
	5204	Direct City and Municipal Grants		
	5206	Title III Grants		
	5210	Other Grants from Governmental Agencies		

CONTROL ACCOUNT NO. 5200 SUB TOTAL*

5300	5301	Revenue from Title XIX-AFDC Clients		
	5302	Revenue from Non-Title XIX Clients		

CONTROL ACCOUNT NO. 5300 SUB TOTAL*

6000		Membership Dues - Individuals		
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CONTROL ACCOUNT NO. 6000 SUB TOTAL*

6100		Assessments & Dues-Local Member Units		
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CONTROL ACCOUNT NO. 6100 SUB TOTAL*

*Must be the same dollar amount as shown on Form 4.

FORM 4S ANTICIPATED PROGRAM REVENUE SUPPLEMENTARY SHEET

Agency Name		2006 Prgm No.		
		(A)	(B)	(C)
Control Acct. No.	Sub-Account Number	Account Description	2005 Revenue Budget	2006 Revenue Budget
6200	6201	Income from Private Pay Clients		
	6202	Income from Title IVA (AFDC Employed Actual) Clients		
	6203	Income from Title XX Clients (Direct Pay Portion Only)		
	6204	Income from 51.42/437 Clients (Direct Pay Portion Only)		
	6205	Income from Client Pick-up and Delivery Charges		
	6206	Income from Client Insurance Carriers (Other than Medicare - Title XVIII)		
	6207	Other Third Party Non-Governmental Income		

CONTROL ACCOUNT NO. 6200 SUB TOTAL*

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6300		Intra-Agency Sales of Supplies&Service		
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CONTROL ACCOUNT NO. 6300 SUB TOTAL *

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6400	6401	Sale of Production		
	6402	Sale of Property & Other Assets		
	6403	Sale of Staff Services		

CONTROL ACCOUNT NO. 6400 SUB TOTAL*

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6500	6501	Interest		
	6502	Dividends		
	6503	Other		

CONTROL ACCOUNT NO. 6500 SUB TOTAL*

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6600		Gains (Losses) on Investment Trans.		
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CONTROL ACCOUNT NO. 6600 SUB TOTAL *

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6900		Miscellaneous Revenue		
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CONTROL ACCOUNT NO. 6900 SUB TOTAL*

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GRAND TOTAL**

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*Must be the same dollar amount as shown on Form 4.

**Must be the same dollar amount as shown on Form 4, on the line titled "TOTAL NON-DHHS REVENUE"